Washington State Department of Social & Health Services

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
CHILDREN'S ADMINISTRATION

ADOPTIVE APPLICANT MEDICAL REPORT
CONFIDENTIAL

DATE:

PHYSICIAN:			RETURN TO:
ADDRESS:			
CITY:	STATE:	ZIP CODE:	

NAME OF APPLICANT:

I hereby authorize my physician to release all the information including information on the items that I have initialed below to the Department of Social and Health Services.

_____
SIGNATURE OF APPLICANT

The above named applicant has applied to adopt a child/ren through our agency. We need to know if this applicant has any chronic, contagious or disabling illnesses that would interfere with the proper care of a child or children on a long-term basis. In particular, we need to know if the applicant has a history of ☐ mental illness, ☐ alcohol and drug usage, ☐ sexual and/or physical abuse, ☐ domestic violence.

DATE FIRST SEEN BY YOU:	DATE OF LAST PHYSICAL EXAMINATION:
SPECIALIST REFERRED TO:	ADDRESS OF SPECIALIST:

REASON FOR REFERRAL:

SIGNIFICANT PAST MEDICAL HISTORY:

CURRENT MEDICAL DIAGNOSIS:

CURRENT MEDICATIONS/S:

PROGNOSIS:

COMMENTS OR IMPRESSIONS:

PHYSICIAN'S SIGNATURE;	DATE